Map -350
(Rev 07/08)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM
CERTIFICATION FORM

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/ID/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

_____ _____
Signature Date

II. HOME AND COMMUNITY BASED (HCBS) WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, SUPPORTS FOR COMMUNITY LIVING (SCL) WAIVER, MICHELLE P (MP) WAIVER, MODEL II WAIVER, AQUIRED BRAIN INJURY (ABI) WAIVER, AQUIRED BRAIN INJURY LONG TERM CARE (ABI/LTC)WAIVER.

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS Waiver program as an alternative to NF placement is requested ☐; is not requested ☐.

_____ _____
Signature Date

B. SCL - This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation or developmental disabilities. Consideration for the SCL Waiver program as an alternative to ICF/ID/DD is requested ☐; is not requested ☐.

_____ _____
Signature Date

C. MP - This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation or developmental disabilities. Consideration for the MP Waiver program as an alternative to ICF/ID/DD is requested ☐; is not requested ☐.

_____ _____
Signature Date

D. MODEL II - This is to certify that I/legal representative have been informed of the Model II Waiver program. Consideration for the Model II Waiver program as an alternative to ICF/ID/DD is requested ☐; is not requested ☐.

_____ _____
Signature Date

F. ABI - This is to certify that I/legal representative have been informed of the ABI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested ☐; is not requested ☐.

_____ _____
Signature Date

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G. ABI/LTC - This is to certify that I/legal representative have been informed of the ABI/LTC Waiver Program. Consideration for the ABI/LTC Waiver Program as an alternative to NF or NF/ABI placement is requested ☐; is not requested ☐.

_____ _____
Signature Date

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____ _____
Signature Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

_____ _____
Signature Date

V. MEMBER INFORMATION

Name: _____ Medicaid Member ID #: _____

_____
(Address)
_____ KY _____ _____
(City) (Zip) (Phone)

Responsible Party/Legal Representative: _____

_____
(Address)
_____ KY _____ _____
(City) (Zip) (Phone)

Signature and Title of Person Assisting with Completion of Form:

_____

Agency/Facility: _____

_____
(Address)
_____ KY _____ _____
(City) (Zip) (Phone)

CLEAR FORM